STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155449	A. BUILDING _____ B. WING _____	C 01/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LAKES NURSING AND REHABILITATION CENTER	516 N WILLIAMS ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00102143.

Complaint IN00102143 - Unsubstantiated due to lack of evidence.

Survey dates: January 19 and 20, 2012

Facility number: 000426
Provider number: 155449
AIM number: 100275480

Survey team:
Carol Miller RN, TC
Shelly Miller-Vice, RN

Census bed type:
SNF/NF: 75
NF: 9
Total: 84

Census payor type:
Medicare: 14
Medicaid: 44
Other: 26
Total: 84

Sample: 3

Northern Lakes Nursing and Rehabilitation was found to be in compliance with with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00102143.

Quality review completed 1/24/12 by Jennie Bartelt, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE